STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

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F0000	This visit was for the Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00122937 and IN00123144. Complaint IN00122937 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323. Complaint IN00123144 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241. Survey Dates: January 30 and 31, 2013 February 1, 4, 5, 6 and 7, 2013 Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870 Survey Team: Virginia Terveer, RN, TC Sue Brooker, RD Julie Call, RN Angela Strass, RN Census bed type:	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 114 Total: 114 Census payor type: Medicare: 22 Medicaid: 72 Other: 20 Total: 114 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 14, 2013 by Randy Fry RN.			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on interview and review of facility documents the facility failed to ensure 1 of 3 residents was cared for in a manner that maintained dignity. (resident A) Finding includes: Interview with the Director of Nursing on 2/6/13 at 9:00 a.m. indicated resident (A) was alert and oriented. She indicated the resident's family member had been visiting with the resident on 1/28/13 and found a clip board hanging on the outside of the resident's door which had documentation of how many times the resident had turned on her call light. The Director of Nursing indicated the family member was upset and she had apologized and filled out a grievance form. She further indicated she was unable to determine who had placed the clip board on the door. The Director of Nursing on 1/30/13 had an inservice and educated the CNA's (certified nursing assistants)	F0241	This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.F241: *All residents of this facility will be cared for in a manner that maintains dignity. *Other residents have the potential to be affected. The clipboard was removed from the resident A's door on 1/28/13 and the c.n.a.s were re-educated on resident rights on 1/30/13. *Facility management conducted a tour of the facility with no other noted instances of posted resident information observed. *Facility staff will receive re-education regarding posting resident information on room doors. Facility management will monitor compliance during Guardian Angel rounds 5x/week going forward. *Results of Guardian Angel audits will be forwarded to	03/09/2013

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	on "Resident Rights and dignity." Review of the inservice indicated dignity was defined as the state or quality of being worthy of honor or respect. This Federal tag is related to complaint IN00123144. 3.1-3(t)		QA&A for tracking and trending monthly for a minimum of 6 months and until the facility has a consistant patten of compliance with a subsequent plan developed and implemented as necessary.	

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F0247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review the facility failed to inform 1 of 2 residents of a roommate change who met the criteria for Admission Transfer and Discharge. (resident #60) Finding includes: On 2/5/13 at 1:30 p.m. interview with resident #60 indicated the facility does not inform him when he gets a new roommate. The resident stated, "Just last night they dumped one in here." Interview with the Social Worker on 2/5/13 at 1:35 p.m. indicated she informs residents of new roommates but resident #60 had gotten a new roommate late in the evening and she did not know about the new admission. The Social Worker indicated nursing staff should have informed the resident prior to the new resident being admitted. On 2/5/13 at 1:45 p.m. the Social Worker was requested to provide a policy on notification of roommates.	F0247	F247: *Residents will receive notice before the resident's room or roommate changes. *Other residents have the potential to be affected. Social Service spoke with resident 60 on 2/5/13 regarding the new admission to his room and addressed concerns voiced. *Nursing staff and social services were re-educated to notify residents when a new admission was expected to be admitted to their room. Social Services will monitor compliance through random interviews 3x/week going forward. *Results of the social service audits will be forwarded to QA&A monthly for a minimum of 6 months and until the faciity has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/09/2013

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	Review of the policy did not specifically indicate residents were to be informed of a new roommate, but the Social worker indicated she or the nursing staff should inform the resident. On 2/6/13 at 9:45 a.m. interview with nursing staff supervisor #1 indicated resident #60 did get a new roommate, which was an emergency admission the night before at 10:00 p.m.. Staff #1 indicated there was no documentation in the clinical record which indicated resident #60 had been informed of a new roommate. 3.1-3(v)(2)			

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F0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on record review and interview the facility failed to ensure 1 of 8 residents reviewed who met the critieria for urinary incontinence, was assessed to determine a urinary	F0272	F272: *Residents of this facility who meet the criteria for urinary incontinence will be assessed to determine a urinary voiding pattern. *Urinary incontinent residents have the potential to be	03/09/2013

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	voiding pattern. (resident #124) Finding includes: On 2/5/13 at 9:00 a.m. review of the clinical record for resident #124 indicated she was admitted to the facility on 2/7/12 with diagnoses including but not limited to Dementia, Hypertension and Hip Fracture. Review of the quarterly MDS (minimum data set) assessment dated 9/2/12 indicated the resident had short and long term memory problems, was non-ambulatory, required extensive assistance of two people for toileting and was frequently incontinent of bowel and bladder. Further review of the record on 2/5/2013 at 1:05 p.m., indicated the resident had been admitted with a urinary catheter but the catheter had been discontinued on 9/7/12. Review of the resident's "Bowel and Bladder Assessment and Management" form dated 12/20/12 indicate the resident scored a total of 16 which indicated the resident was a poor candidate for toileting/likely candidate for incontinence management. The progress note indicated "Resident is unaware of toileting needs due to dementia. Incontinent of Bowel and Bladder."		affected. For resident #124 a toileting pattern has been established and care planned. The facility has reviewed residents with incontinence to ensure thorough assessments were completed and appropriate toileting plans were implemented. *MDS staff were re-educated to complete thorough assessments for residents with incontinence and implementing appropriate toileting plans. Nursing staff was re-educated on the process of completing 3 day voiding diaries. DON/designee will monitor compliance with appropriate urinary voiding patterns by auditing 5 incontinent residents weekly going forward. *Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	

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	On 2/5/13 at 1:00 p.m. interview with the MDS (minimum Data Set) Coordinator indicated the facility uses the "Vocal EX System" (electronic head set used by the staff) to determine a voiding pattern, but the system does not have a set toileting time for the residents. Further interview indicated the facility did not have a system to accurately determine a urinary voiding pattern for residents to accurately assess the residents potential to establish continence of urine or to establish a toileting plan or schedule to meet the residents needs. 3.1-31(a)			

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F0279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review the facility failed to ensure care plans were written for the potential for skin break down and incontinence of bowel and bladder for 1 resident (#124), and failed to develop a written care plan for 1 resident (D) who was at risk for falls in a sample of 51 residents reviewed for care plans. Findings include: 1. On 2/6/13 at 1:00 p.m. review of the clinical record for resident #124 indicated she was admitted to the	F0279	F279: *Care Plans will be written for residents at risk for skin break down, incontinence of bowel and bladder and for falls. *Residents who are at risk for skin break down, incontinent of BB and at risk for falls have the potential to be affected. A care plan was developed for resident D to address fall risk, and for resident #124 at risk for skin breakdown and bowel and bladder incontinence. The facility reviewed all resident assessments for falls, incontinence, and risk for skin brerakdown and implemented care plans as appropriate.	03/09/2013

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	facility on 2/7/12 with diagnoses including but not limited to dementia, hypertension and a hip fracture. Review of the MDS (minimum Data Set) Assessment dated 12/7/12 indicated the resident required extensive assistance with bed mobility, transfers and toileting. The resident was also assessed as being non-ambulatory and frequently incontinent of bowel and bladder. Review of the "Braden Scale-For Predicting Pressure Sore Risk" dated 12/20/12 indicated the resident had a score of 13 which put her in the "High Risk" category for developing pressure ulcers. On 2/6/13 at 1:30 p.m. review of the clinical record for resident #124 indicated there were no written care plans which addressed the residents incontinence of bowel and bladder, toileting schedule, or her risk for skin breakdown. Interview with nursing staff supervisor #1 on 2/6/13 at 2:50 p.m. indicated she had reviewed the resident's clinical record and confirmed the resident did not have written plans of care which addressed her		*Licensed staff were inserviced to develop care plans for residents at risk for skin breakdown, falls and bowel and bladder incontinence. UM/designee will monitor compliance with care plan development for high risk skin and falls during admission audits and routine IDT walking rounds. DON/designee will monitor compliance with development of bowel and bladder incontinence care plans by auditing 5 incontinent residents weekly x 1 month then 1 resident weekly x 3 months then 1 resident monthly thereafter. *Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the faciity has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	

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	incontinence, toileting schedule and risk for skin breakdown. 2. The clinical record review for Resident D on 2-7-2013 at 10 a.m., indicated the resident was admitted to the facility on 11-6-2012 with diagnoses including but not limited to: ischemic colitis, acute renal failure, atrial fibrillation and diabetes. A fall risk assessment was completed on 11-6-2012 with a score of a "9" which indicated the resident was not considered a "high risk." The nursing assessment completed on 11-6-2012 indicated the resident was alert, required assistance for ambulation, was full weight bearing and used a wheelchair for mobility. The assessment indicated the resident was dependent for bathing, toileting and bed mobility. The assist for transfer was not assessed. A physical therapy evaluation completed on 11-6-2013 for Resident D indicated the reason for the referral was related to a recent hospitalization which resulted in a decrease in muscle strength, bed mobility, transfers and walking. The evaluation indicated the resident was a fall risk			

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	and the resident was alert and oriented to self. The physical therapy evaluation indicated the resident was able to safely transfer from the bed to the wheelchair and from a sitting position to standing position in which both tasks required maximum assistance. The MDS (Minimum Data Set, an assessment completed to assess the status of a resident) discharge assessment completed 11-12-2012 indicated Resident D required extensive assistance of 2+ persons for bed mobility, toileting and transfers. Resident D had an assistive device of a wheelchair and the assessment indicated the resident was not steady when moved from a seated to a standing position. The resident was only able to stabilize with human assistance. Previous MDS admission assessment on 9-17-2012 and a MDS discharge assessment on 10-8-2012 indicated Resident D required extensive assistance of 2+ person for bed mobility, toileting and transfers. A review of a "Report of Incident" indicated Resident D fell on 11-10-2012 while he transferred self from the bed to the wheelchair. The			

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	report indicated chair and bed alarms were implemented after the fall. No care plan for fall risk was implemented after the fall. Care plans implemented on 11-6-2012 included physical and occupational therapy care plans. An activities of daily living care plan was implemented on 11-7-2012. An interview with the DON (Director of Nursing) on 2-7-2013 at 12:00 p.m., indicated there was not a care plan developed for fall risk for Resident D after the fall on 11-10-2012. On 2-6-2013 at 12:00 p.m., a policy titled "Care Plan, Comprehensive" dated 2008 was obtained from RN #22. The policy included but was not limited to the following: "...The care plan is individualized by identified resident problems...." "...The care plan is based on using fundamental information gathered by the MDS, resident assessment protocols and information gathered through regular observation and assessment..." "...The care plan becomes a comprehensive tool for the IDT (Interdisciplinary Team) to utilize as a reference for resident specific probems and approaches to establish guidance on meeting the individual			

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	needs of the resident..." "...Resident progress is regularly evaluated in each category with approach revisions and updates as appropriate..." On 2-6-2013 at 8:45 a.m., a policy titled "Falls Management" dated October 2010 was obtained from RN#22. The policy included but was not limited to the following: "Fall Prevention Procedure" "...Initiate a fall prevention care plan when appropriate..." 3.1-35(a) 3.1-35(b)(1)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow physician orders for completion of treatments for 2 of 3 residents (E and F) in a sample of 3 reviewed for completion of treatments, and the facility failed to ensure medications were administered by qualified staff for 1 of 10 residents (#238) in a sample of 10 residents under the care of LPN #21 who received medications in the Rehabilitation Unit. Findings include: 1. The clinical record review on 2-4-2013 at 3:47 p.m., indicated Resident E was admitted to the facility on 12-18-2012 for wound treatments. The physician's orders indicated the resident's diagnoses included but not limited to: edema, history of hepatitis C, cirrhosis of the liver, hyponatremia and upper gastrointestinal varicies. On 1-4-2013 physician orders were	F0282	F282: *The facility will follow physician orders for treatments and medications will be administered by qualified personnel. *All residents have the potential to be affected. Resident #238 was reviewed with no negative outcome. Resident F orders were updated to include trach care every shift. Resident E no longer resides in the facility. The facility reviewed all residents with a tracheostomy to ensure orders were in place and implemented as appropriate. One time review of the TAR documentation was completed with interventions implemented as appropriate. *Licensed staff were re-educated to include trach care on the physician's orders and MAR/TAR. All staff were re-educated on who is qualified to give residents medication. UM/designee will monitor compliance with trach care orders through medical record review 5x/week going forward. UM/designee will monitor medications are passed qualified personnel through random observations 2x/week going forward. *Results of audits will be forwarded to QA&A committee for tracking and trending monthly	03/09/2013

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	updated for the lower extremity wound care and included: 1. Gentamycin 1 gram with Dakins 50 milliliters with 1 liter of normal saline for the BID (2 times a day) moist gauze dressing to the left calf wounds. 2. Xeroform dressing daily to the left and right dorsal foot ulcers. 3. Flexmaster ace to both legs daily and with dressing changes. The treatment administration record for January 2013 indicated the following dates lacked initials for the Gentamycin and Dakins solutions moist gauze dressing to the left calf wound ordered treatments: 1. 1-8-2013 11 p.m. - 7 a.m. shift 2. 1-9-2013 3 p.m. - 11 p.m. shift The treatment administration record for January 2013 indicated the 1-9-2013 treatment on the 3 p.m. to 11 p.m. shift lacked initials for the xeroform dressing to the left and right dorsal foot ulcers daily wound treatment. The treatment administration record for January 2013 lacked initials for the Flexmaster ace to both legs with dressing change on 1-8-2013 during the 11 a.m. to 7 a.m. shift and for 1-9-2013 during the 3 p.m. to 11 p.m.		for a minimum of 6 months and until the faciity has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	

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	shift. The nurse's notes did not contain entries for 1-8-2013 during the 11 p.m. to 7 a.m. shift. There was not documentation in the nurses notes during the 24 hour period on 1-9-2013. An interview with the DON (Director of Nursing) on 2-7-2013 at 12:00 p.m., indicated the treatments were not completed as evidenced by the missing initials on the treatment administration record. 2. An observation of Resident F on 2-6-2013 at 12:01 p.m., indicated the resident was in the hallway in front of nurse's station in a reclining wheelchair with the brakes not secured. The tracheostomy (trach) dressing was clean, and a trach cannula and collar were in place. The clinical record review on 2-7-2013 at 10:30 a.m., indicated the resident was admitted on 9-26-2012. Diagnoses included but were not limited to: spina bifida, chiari malformation, seizures, chronic respiratory failure, tracheostomy, HTN (hypertension), GERD (gastroesophageal reflux), dysphagia, and g-tube (gastrostomy			

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	tube - a feeding tube). MDS (minimum data set) quarterly assessment dated 1-3-2013 indicated Resident F required extensive assistance of 2 for bed mobility, transfers and toileting, extensive assistance of 1 for dressing and personal hygiene and total dependence of 1 for locomotion on and off the unit. The BIMS (brief interview for mental status) indicated the resident never/rarely understood. The MDS indicated Resident F used a wheelchair and had special treatments which included tracheostomy care. A care plan for trach care was provided by the DON on 2-7-2013 at 12:00 p.m. The care plan included but was not limited to the following interventions: "trach care every shift; change inner cannula daily; change tube corregated hose and mask every week on Sunday. The physician's orders for January 2013 were signed by the physician and included trach orders as follows: -suction trach every shift and as needed -change corregated tubing weekly on Sunday			

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	-change inner cannula daily The physician's orders lacked trach care every shift. A review of the Medication Administration Record and the Treatment Administration records for January 2013 lacked documentation for the physician orders for the tracheostomy care that included the following: -suction trach every shift and as needed -change corregated tubing weekly on Sunday -change inner cannula daily. The Medication and Treatment Administration records lacked the "trach care every shift." An interview with the West Hall Unit Manager on 2-7-2013 at 10:40 a.m. indicated Resident F had a tracheostomy with an inner trach cannula and collar. The West Hall Unit Manager indicated she was not aware the tracheostomy care orders were not on the MAR (Medication Administration Orders) or TAR (Treatment Administration Orders). The West Hall Unit Manager was unable to locate the tracheostomy orders on the MAR or TAR for January 2013. The West Hall Unit Manager did not know how staff who			

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	were new to the unit would know when to provide tracheostomy care. A review of the nurse's notes, MAR and TAR from January 1, 2013 through February 6, 2012 lacked documentation of the tracheostomy care for: 1-1-2013 all shifts (day = 7 a.m. - 3 p.m.; 2nd = 3 p.m. - 11 p.m.; 3rd - 11 p.m. - 7 a.m.) 1-2-2013 day shift 1-3-2013 all shifts 1-4-2013 day and 3rd shift 1-5-2013 all shifts 1-6-2013 all shifts 1-7-2013 all shifts 1-8-2013 all shifts 1-9-2013 all shifts 1-10-2013 day and 3rd shift 1-11-2012 all shifts 1-12-2013 all shifts 1-13-2013 all shifts 1-14-2013 all shifts 1-15-2013 all shifts 1-16-2013 all shifts 1-17-2013 all shifts 1-18-2013 all shifts 1-19-2013 all shifts (The resident was admitted to the hospital after 1-19-2013 and returned 1-22-2013.) 1-23-2013 day and 3rd shift 1-24-2013 all shifts			

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	1-25-2013 all shifts 1-26-2013 all shifts 1-27-2013 all shifts 1-28-2013 all shifts 1-29-2013 all shifts 1-30-2013 2nd and 3rd shifts 1-31-2013 all shifts 2-1-2013 1st and 3rd shifts 2-2-2013 all shifts 2-3-2013 2nd and 3rd shifts 2-4-2013 2nd and 3rd shifts 2-5-2013 all shifts 2-6-2013 all shifts A review of the comprehensive physician's order sheet on 2-7-2013 at 12:23 p.m. provided by the DON indicated the following: "2-7-2013 Add to treat sheet Trach Care q (every) shift" An interview with the DON on 2-7-2013 at 12:23 p.m., indicated the nurse's notes or the MAR/TAR should have had the documentation regarding the tracheostomy care was done every shift. The DON indicated the treatments should have been on the TAR and it was determined the treatment orders for the trach care were not present on the January or February 2013 TAR. The DON was unable to provide any further documentation that the trach care			

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	was completed during January and February 2013. A policy "Tracheostomy Care" dated 2008 was provided by the DON on 2-7-2013 at 12:23 p.m., indicated but was not limited to the following: "...Complete documentation in resident's clinical record. Include procedure performed, resident tolerance, stoma site appearance, adverse reactions, etc..." 3. During the noon meal in the Rehabilitation dining room on 1-30-2013 at 12:20 p.m., the Food Service Manager was observed taking a small, clear, plastic medication cup from LPN #21 which contained medications for Resident #238. The Food Service Manager gave the small, clear, plastic medication cup containing medications to Resident #238 and the resident was observed to put the medications in her mouth followed by swallowing a liquid. An interview with the Food Service Manager on 1-30-2013 at 12:21 p.m., indicated Resident #238 asked her to get her pills from the nurse. The Food Service Manager indicated she gave the pills to the resident.			

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	An interview with Resident #238 on 1-30-2013 at 12:22 p.m., indicated she had 3 pills she just swallowed. The resident indicated "I take these pills with my lunch." The resident indicated she was unable to identify the exact medications she just swallowed. An interview with LPN #21 on 2-5-2013 at 10:25 a.m., indicated he thought he gave the prepared medications for Resident #238 on 1-30-2013 during the noon meal to RN #16 and not to the Food Service Supervisor. An interview with RN #16 on 2-5-2013 at 10:40 a.m., indicated if she had helped with dining last week, it would have been in West Hall hall dining room. RN #16 indicated she had not passed medications during the past week back through 1-30-2013. An interview with the Food Service Manager on 2-5-2013 at 1:20 p.m., indicated she gave Resident #238 her medications during the lunch meal on 1-30-2013. An interview with LPN #21 on 2-5-2013 at 2:37 p.m., indicated Resident #238's usual noon medications were as follows:			

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	hydralazine 25 mg (milligrams) po (by mouth) 2 times daily and pyridostigmine BR (Bromide) 60 milligrams-take 1/2 tablet po every 6 hours. A review of Resident #238's Medication Administration Record on 2-5-2013 at 10:15 a.m., indicated pyridostigmine Bromide 30 mg po every 6 hours was documented as given with initials of LPN #21 on 1-30-2013 at noon. The medication hydralazine HCl 25 mg tablet was documented as given at 11:00 a.m. on 1-30-2013 by initials of LPN #21. The controlled substance record for hydrocodone-APAP 5-325 mg was documented as 1 tablet given to the Resident #238 on 1-30-2013 at 12:30 p.m. by LPN #21. A policy titled "General Dose Preparation and Medication Administration" dated May 2010 was provided by RN Director of Clinical Management on 2-5-2013 at 10:08 a.m., indicated the following: "1. Facility staff should comply with facility policy, Applicable Law and the State Operations Manual when administering medications." An interview with the RN Director of Clinical Management on 2-5-2013 at			

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	10:08 a.m., indicated the Medication Administration policy did not indicate who can give medications. The RN Director of Clinical Management indicated "authorized personnel can give medications". "Authorized personnel" was defined by the RN Director of Clinical Management as a "RN (Registered Nurse), LPN (Licensed Practical Nurse) or QMA (Qualified Medication Aide)." This Federal tag is related to complaint IN00122937. 3.1-35(g)(1) 3.1-35(g)(2)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview the facility failed to ensure 1 of 15 residents (Resident #124) in a sample of 15 residents reviewed for activities of daily living, cleanliness and grooming, had her hair combed when awake and in the dining/activity room. Fnding includes: Review of the clinical record for resident #124 on 2/6/13 at 1:30 p.m. indicated the resident was admitted to the facility on 2/7/12 with Diagnoses including but not limited to dementia, hypertension and a hip fracture. Review of the MDS (minimum data set) assessment dated 9/2/12 indicated the resident required extensive assistance of staff for transfers, dressing and personal hygiene. Review of a care plan written for resident #124 dated 10/9/12 indicated	F0312	F312: *Residents hair and nails will be well groomed. Resident #124 fingernails were cleaned and hair was combed. *All residents have the potential to be affected. The facility observed resident fingernails and hair during Guardian Angel rounds and completed ADL care as appropriate. *Nursing staff were re-educated to ensure ADL care, including nail and hair care, is completed timely. Guardian Angels will monitor compliance with ADL care 5x/week.going forward. *Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/09/2013

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	the following: Problem: Resident has difficulty at times making self understood due to dementia progression Goal: Resident will be able to make needs known daily thru next review Interventions: Staff will anticipate needs daily thru next review Staff to assist with and anticipate residents needs and wants Residents psycho/social well being will remain intact Provide simple yes/no questions to assist resident with communication Do not rush resident or show impatience when resident is attempting to communicate Monitor resident communication and offer assist with all means of communication while encouraging resident to participate in care Allow resident time to process information. Observation of the resident on 1/30/13 at 10:50 a.m. indicated the			

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	resident was seated in her wheelchair in the activity/dining area. The resident's hair had not been combed and her fingernails had debris under and around the nails. Observation of the resident on 1/31/13 at 11:00 a.m. indicated the resident was seated in her wheelchair in the activity/dining area. The resident's hair had not been combed and she was observed to have a large amount of debris under her fingernails which she was picking out of her nails and showing this writer. 3.1-38(a) 3.1-38(3)(B) 3.1-38(3)(E)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review the facility failed to ensure 1 of 3 residents who met the criteria for pressures sores, was provided a wheelchair cushion to prevent pressure ulcers. (resident #124) Finding includes: On 2/4/13 at 9:00 a.m. review of the clinical record for resident #124 indicated she was admitted to the facility on 9/2/12 with Diagnoses including but not limited to Dementia, Hypertension, Hip Fracture and Urinary Tract Infection. Review of the most recent quarterly MDS (Minimum Data Set), dated 9/2/12 indicated the resident had short and long term memory	F0314	F314: *Residents of this facility who meet the criteria for pressure sores will have a cushion provided for their wheelchair. The wheelchair cushion was replaced for resident #124 during the survey. *Residents who are at tisk for pressure sores have the potential to be affected. The facility performed a one-time audit for all residents at risk for skin breakdown to ensure wheelchair cushions were in place. Wheelchair cushions were implemented as appropriate. *Nursing staff were re-educated regarding providing residents at risk for breakdown with a wheelchair cushion. UM/Guardian Angels will monitor wheelchair cushions are in place 5x/week going forward. *Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facilitiy has a consistant pattern of	03/09/2013

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	problems and required extensive assistance of two for transfers. The resident was also assessed as being non-ambulatory. Review of the "Braden Scale-For Predicting Pressure Sore Risk" dated 12/20/12 indicated the resident had a score of 13 which put her in the "High Risk" catagory for pressure Ulcers. Review of the resident's admission physician orders dated 9/2/12, indicated the resident had an order for a pressure reduction wheelchair cushion. Observation of the resident seated in her wheelchair on 1/30/13 at 11:00 a.m., 1/31/13 at 11:10 a.m., 2/1/13 at 10:30 a.m. and 2/4/13 at 11:15 a.m. indicated the resident did not have a pressure relieving cushion in the seat of her wheelchair. Interview with nursing staff supervisor #1 on 2/4/12 at 2:00 p.m. indicated the resident did have an order for a wheelchair cushion but she did not know where the cushion was. 3.1-40(a)(2)		compliance with a subsequent plan developed and implemented as necessary.	

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	155446	A. BUILDING 00 B. WING	02/07/2013

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review the facility failed to keep catheter tubing off the floor for 2 of 2 residents (Resident #76 and Resident #219) who were reviewed for catheters in a sample of 22 residents who met the criteria for urinary catheter use. Findings include: 1. Review of the clinical record for Resident #76 on 2/4/13 at 4:00 p.m., indicated the following: diagnoses included, but were not limited to, BPH (benign prostatic hypertrophy), urinary retention, and anxiety. A physician's order for Resident #76, dated 11/7/12, indicated to monitor Foley catheter q (every) shift, note abnormals in nurse's notes, change	F0315	F315: *Catheter tubing be kept from touching the floor. Resident #76 and #219 catheter tubing was observed to ensure proper positioning. *Residents who have catheters have the potential to be affected. The facility observed residents with catheters to ensure tubing was correctly positioned. *Facility staff were re-educated regarding the proper positioning of catheter tubing. Guardian Angels will monitor compliance with catheter tubing positioning through routine rounds 5x/week going forward. *Results of the Guardian Angel audits will be forwarded to the QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/09/2013

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catheter monthly, and change bag weekly.

A facility care plan for Resident #76, with a date of 5/10/12, indicated the problem area of high risk for urinary tract infection due to indwelling catheter. Approaches to the problem included, but were not limited to, ensure catheter tubing and drainage bag are properly positioned to prevent urinary backflow or contamination.

During an observation on 1/31/13 at 3:08 p.m., Resident #76 was observed seated in his wheelchair in the front lobby. He was then observed to self-propel his wheelchair into the large lounge/activity area. His catheter tubing was dragging on the floor.

During an observation on 2/1/13 at 9:19 a.m., Resident #76 was observed seated in his wheelchair in his room. His catheter tubing was observed on the floor.

During an observation on 2/1/13 at 2:55 p.m., Resident #76 was observed seated in his wheelchair in his room. His catheter tubing was observed on the floor.

During an observation on 2/4/13 at

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	3:55 p.m., Resident #76 was observed seated in his wheelchair in his room. His catheter tubing was observed on the floor. 2. During an observation on 1-31-2013 at 12:30 p.m., Resident #219 was sitting in a wheelchair in his room as housekeeping staff served his lunch tray. The resident's urinary catheter drain tube was observed on the floor under the wheelchair. During the an interview with Resident #219 on 1-31-2013 at 2:20 p.m., the resident's urinary catheter drain tubing was observed on the floor under the wheelchair. During an observation on 2-4-2013 at 10:06 a.m., Resident #219 was in the therapy room and seated in a wheelchair with the urinary catheter drain tubing observed on the floor under the wheelchair. During an observation on 2-4-2013 at 10:10 a.m., Resident #219) was being pushed in a wheelchair in the therapy room and out into the hall by PTA (Physical Therapy Assistant) #25 with the urinary catheter drain tubing dragging on the floor under the wheelchair.			

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	During an observation on 2-4-2013 at 12:00 p.m., Resident # 219 was in his room sitting in a wheelchair with the urinary catheter drain tubing observed on the floor under the wheelchair. An interview with LPN #23 on 2-4-2013 at 2:24 p.m., indicated it was the responsibility of the nursing staff, CNAs (Certified Nursing Assistants) and therapy staff to be sure the catheter bag and tubing were in correct placement and not on the floor. An interview with the Facility Rehabilitation Director #26 on 2-4-2013 at 2:54 p.m., indicated the therapy staff was aware of the care of the foley catheter bag and it should be covered, placed lower than the bladder and the drain tubing should not be on the floor. The clinical record review for Resident #219 on 2-4-2013 at 11:35 a.m., indicated diagnoses included but were not limited to: metastatic renal cancer, anemia, cellulitis and pulmonary edema. Physician orders on the plan of treatment for January 2013 indicated: foley catheter 16FR (French-a measurement for the size of a foley			

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	catheter), I (intake) & O (output) every shift with foley catheter and foley catheter care every shift. The catheter need evaluation and care plan dated 12-20-2012 and 1-25-2013 had interventions that included but were not limited to "ensure catheter tubing and drainage bag are properly positioned to prevent urinary back-flow or contamination." 3.1-41(a)(2)			

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a safe environment on the memory care unit for 17 of 18 ambulatory residents who had access to a coffee pot, and failed to prevent falls with injuries for 2 of 9 residents (#124 and B) who met the criteria for falls with injury. This deficient practice resulted in falls with a fractured arm and hip, and a facial injury. Findings include: 1. On 2/4/13 at 10:47 a.m. resident #116 who resides on the memory care unit was observed to walk up to a coffee pot, which was on and had coffee in the carafe, touched the edge of the heating element and stated "that is hot". Staff were told by writer the resident had touched the coffee pot. Interview with CNA # 2 on 2/4/13 at 10:50 a.m. indicated the coffee pot is used for the staff to get coffee for the	F0323	F323; *Residents #124 and B were assessed and interventions implemented as appropriate. The coffee pot was moved to a secure location and accessible only to employees during the survey. *All residents have the potential to be affected. The facility reviewed residents with falls since 1/1/13 to ensure appropriate interventions were in place and care plan updated a appropriate. Facility management toured the facility during the survey to ensure there were not any other coffee pots accessible to the resident.s . *Nursing staff and IDT were re-educated regarding implementing falls interventions for residents at risk for falls and updating the resident's plan of care. Facility staff were re-educated regarding not having coffee pots accessible to residents. DON/designee will monitor compliance with fall intervention implementation through random audit/observation of 3 residents with falls/week. Audits/observations will include all 3 shifts. ED/designee will audit that coffee pots are not accessible to residents through facility rounds 2x/week. *Results	03/09/2013

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	residents. The coffee pot was observed sitting on a small counter next to the washer and dryer in the kitchen area, which is open to the dining/activity area. CNA #2 was queried about the concern of residents touching and/or burning themselves and she indicated the staff redirect the residents away from the pot. On 2/4/13 at 11:00 a.m. interview with the nursing staff supervisor #1 indicated 17 of 18 residents residing on the memory care unit were ambulatory. 2. Resident B was observed on 2-6-2013 at 12:09 p.m., in the dining room, sitting in wheelchair with a chair alarm secured on the wheelchair. A cast was observed on the left lower arm. The clinical record review on 2-6-2013 at 11 a.m., indicated Resident B was admitted to the facility on 8-7-2012 with diagnoses including but not limited to: fractured left arm, hypertension, depression, gastroesophageal reflux, pacemaker left chest, atrial fibrillation and vitamin D deficiency. The recapitulation for January 2013 was signed by the physician on 1-3-2013 and treatment orders included "may use bed and chair		of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	

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	alarms due to frequent falls." The fall risk evaluation completed 8-7-2012 indicated a score of 16. A score of 10 or above represented "high risk." A fall risk care plan was developed on 8-7-2012 with the following interventions: provide adequate lighting, monitor side effects of medications, keep call light in reach, encourage use of call light, keep floors free of spills and clutter, monitor for unsteady gait and balance, instruct to avoid sudden position changes; labs as ordered, assess toileting needs, provide verbal safety cues, keep assistive devices in reach - wheelchair, physical and occupational therapy evaluation and treatment, and pressure sensor pad for bed and wheelchair. The fall risk care plan was updated on the following dates: 8-14-12 - updated with "educated about locking wheelchair brakes." 8-28-2012 - changed wheelchair 9-7-2012 - rollback device on chair 9-17-2012 - gripper socks, bed alarm and chair alarm 1-9-2013 - educated to use call light due to left arm fracture.			

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	On 1-8-2013 at 9 a.m., Resident B was found on the floor with pain to the left wrist. The report of incident did not indicate use of the bed or chair alarm. The Verification of Investigation indicated the follow up actions included "alarms in place to alert staff of any attempt at self transfers." An order for an x-ray for the left wrist was obtained on 1-8-2013. Resident B was seen in the emergency department on 1-8-2013. The consulation report dated 1-10-2013 indicated the resident had a left distal raduis and ulnar fracture. On 1-10-2013 at 4:50 a.m., Resident B was found on the floor. The report of incident did not indicate the bed or chair alarms were in place. The resident was transferred to the hospital. The consultation report dated 1-10-2013 indicated a left intertrochanteric hip fracture. A review of the Verification of Investigation dated 1-9-2013 indicated the bed and chair alarms were placed as part of the follow up action to the fall on 1-8-2013. A review of the Verification of Incident Investigation report for the fall on			

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	1-10-2013 at 4:50 a.m., did not indicate use of alarms. The Report of Incident dated 1-10-2013 at 4:50 a.m. and completed by LPN #27 indicated Resident B was found on floor with pain to the left leg. Additional circumstances that included " Alarm Activated/Sounding " and " Alarm Failure or Device Removal " were not checked on the Report of Incident form for 1-10-2013. A review of the AccuNurse (documentation computer program for CNAs) documentation provided by RN #22 on 2-6-2013 at 10:00 a.m. for CNAs indicated the prompt, " alarm checked ? " , was answered " no " for 1-8-2013 at 2:00 a.m. and 6:41 a.m. and 1-10-2013 at 1:29 a.m. and 3:45 a.m. An interview with the DON on 2-7-2013 at 9:20 a.m., indicated there were no bed or chair alarms in place prior to the fallson 1-8-13, and prior to the fall on 1-10-13 which resulted in a left hip fracture. 3. On 2/6/13 at 1:00 p.m. review of the clinical record for resident #124 indicated she was admitted to the facility on 2/7/12 with diagnoses including but not limited to dementia, hypertension and a hip fracture.			

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Review of the MDS (Minimum Data Set) Assessment dated 9/2/12 indicated the resident had short term and long term memory problems and was non-ambulatory.

On 2/6/13 at 1:30 p.m. review of the resident's "Fall Risk Assessment" dated 12/20/12 indicated the resident was a high risk for falls. Review of the physician orders dated 2/7/12 indicated the resident was to have a sensor pad on her bed and wheelchair.

Interview with the Director of Nursing on 2/4/13 at 2:30 p.m. indicated the resident fell on 1/22/13 at 2:40 p.m. The resident was found laying on her right side next to her bed with a bloody nose, the physician and family were notified. On 2/4/13 at 2:35 p.m. review of the fall investigation indicated the staff had not activated the resident's sensor alarm on her bed.

This Federal tag is related to complaint IN00122937.

3.1-45(a)(1)
3.1-45(a)(2)

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review the facility failed to provide clinical rationale for the use of a psychotropic medication for 1 resident (Resident #15) of 10 residents reviewed for unnecessary medication. Findings include: Review of the clinical record for Resident #15 on 2/4/13 at 8:43 a.m.,	F0329	F329: *Resident #15 medication was reduced 2/5/13. *All residents receiving psychotropic medications have the potential to be affected. All residents on psychotropic medications were reviewed to ensure documentation was present to include rationale for use of the medication with gradual dose reduction initiated as appropriate. *IDT were re-educated on the process for GDR and documentation requierments for residents on psychotropic medication. IDT will	03/09/2013

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	indicated the following: diagnoses included, but were not limited to, UTI (urinary tract infection), pneumonia, weakness, edema, puritis (itching), anal fissure, chronic back pain, leg cramps, glaucoma, allergic conjunctivitis, failure to thrive, metastatic CA, restless leg syndrome, anemia, depression, anxiety, lung mass/adenocarcinoma, dementia with delusions, and insomnia. Resident #15 was placed on Hospice services on 12/12/10. A hospital Progress Note for Resident #15, dated 4/29/11, indicated the resident was hospitalized for belligerence, and challenging and accusatory behaviors. The note also indicated the Psychiatrist started Risperdal 1.5 mg (milligrams) q (every) HS (hour of sleep). An Interdisciplinary Psychopharmacological Review for Resident #15, dated 6/17/11, indicated she received Risperdal 1.5 mg HS (hour of sleep), for dementia with delusions. Physician orders for Resident #15, dated for the month of February, 2012, indicated Risperdal 1.5 mg HS. The orders also indicated Risperdal		review psychotropic drug regimen during walking rounds quarterly and the consultant pharmacist will monitor compliance with GDR during monthly reviews. *Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	

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	0.5 mg q 6 hours PRN (as needed) for unreasonable anger, agitation, and bullying. A Social Progress Notes for Resident #15, dated 2/16/12, indicated she had not exhibited any signs or symptoms of changes in mood and or behaviors. An Interdisciplinary Psychopharmacological Review for Resident #15, dated 3/21/12, indicated she received Risperdal 1.5 mg q HS. The review did not recommend any changes in her medication. The review also indicated a dose reduction had not been attempted and a reduction was not contraindicated per MD note. An Interdisciplinary Psychopharmacological Review for Resident #15, dated 6/28/12, indicated she continued to receive Risperdal. The review also indicated the team did not recommend any changes related to the Risperdal. The form indicated a dose reduction had not been attempted. A physician's order for Resident #15, dated 6/8/12, indicated to discontinue Risperdal 0.5 mg q 6 hours PRN due to non-use.			

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	A Social Progress Notes for Resident #15, dated 7/18/12, indicated she had not exhibited any noted signs or symptoms of delirium. The note also indicated she received Risperdal 1.5 mg daily for diagnosis of dementia with delusions. No recent delusions had been noted. The note further indicated she remained on behavior tracking to monitor: trouble sleeping, restless, fidgeting, confrontational, negativity, irritability, and attention seeking. None of the behaviors had been noted. The note also indicated the PRN Risperdal was discontinued on 6/18/12 due to non-use. A Social Progress Notes for Resident #15, dated 11/15/12, indicated no signs of psychosocial distress. A physician's order for Resident #15, dated 12/16/12, indicated Ativan 0.5 mg q 4 hrs PRN. A Social Progress Notes for Resident #15, dated 12/18/12, indicated a new order per Hospice for Ativan 0.5 mg q 4 hours PRN. A Nurse's Notes for Resident #15, dated 12/18/12, indicated the writer spoke with the niece to speak with Hospice about having a meeting to discontinue medications and keep on			

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	comfort measures only which is what family wishes at this time. An Interdisciplinary Psychopharmacological Review for Resident #15, dated 1/18/13, indicated a recommendation was made by the team to the Psychiatrist to decrease the Risperdal to 1 mg for 2 weeks and to look at discontinuation if there were gradual dose reduction issues. A Consultation Report for Resident #15, dated 1/24/13, indicated a gradual dose reduction of Risperdal was recommended by the facility. The recommendation was declined by the Nurse Practitioner because a gradual dose reduction was clinically contraindicated. The report further indicated the resident was on Hospice care for lung cancer and withdrawing Risperdal could cause a re-emergence of behaviors. Review of the Behavior/Intervention Monthly Flow Records for Resident #15 indicated the facility was tracking the behaviors of: attention seeking, confrontational/negativity/irritability, trouble falling asleep, and restless/fidgeting. The Behavior/Intervention Monthly Flow Records for the months of March			

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	2012, April 2012, May 2012, June 2012, July 2012, August 2012, September 2012, October 2012, November 2012, December 2012, and January 2013 did not indicate any behaviors recorded for Resident #15. A facility care plan for Resident #15, with a start date of 6/15/12 and re-evaluation dates of 9/2012, 12/2012, and 3/2013, indicated the problem area of potential behavior disturbance related to: dementia with delusions and confrontational. The goal to the problem indicated to reduce episodes of behavior to 0 x per month x 90 days. Interventions to the problem included, but were not limited to, monitor significant side effects of antipsychotic medications and notify MD as appropriate: Risperdal, and IDT (Interdisciplinary Team) quarterly review. A facility care plan for Resident #15, with a start date of 11/2011, indicated the problem area of resident has a history of itching/scratching due to neuro- dermatitis. The goal to the problem indicated scratching will be reduced to less than daily thru next review. Interventions to the problem included, but were not limited to, notify social services of excessive			

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	scratching. Physician's orders for Resident #15, dated for month of February, 2013, indicated Risperidone 1.5 mg HS for dementia with delusions (started 4/29/11). Social Service #4 was interviewed on 2/4/13 at 10:50 a.m. During the interview she indicated behaviors were recorded on a behavior flowsheet with the MARS and TARS. She also indicated behaviors of resident were reviewed by the team each morning in morning meeting. She further indicated Resident #15 was followed by an outside Psychiatrist for her psychotropic medications. Social Service #4 was interviewed on 2/5/13 at 8:45 a.m. During the interview she indicated Resident #43 previously had the behavior of picking at her skin until it bled. She also indicated the resident had not displayed that behavior since she started with the facility in late August, 2012. She further indicated the only recommendation made by the facility to the physician recommending a decrease in the Risperdal was on 1/24/13.			

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	Social Service #4 was interviewed on 2/7/13 at 10:50 a.m. During the interview she indicated the meeting between the niece of Resident #43, who is her POA (Power of Attorney), and Hospice concerning her medications had not yet happened since the niece lived out of town. A facility policy "Gradual Dose Reduction: Implication for Prescribers", dated 6/9/10 and provided by the Administrator on 2/5/13 at 1:50 p.m., indicated "...Antipsychotic GDR (gradual dose reduction)...After the first year: a GDR must be attempted annually, unless clinically contraindicated...Behavioral symptoms related to dementia: The GDR may be considered clinically contraindicated if the: Resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; AND Physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior...." A 2010 Nursing Spectrum Drug Handbook, indicated adverse reactions of Risperdal included, but were not limited to, "...pruritus			

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	(itching)...rash, dry skin, seborrhea..." 3.1-48(b)(1) 3.1-48(a)(4)			

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F0364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F0364	F364; *Food prepared in the facility kitchen will be served at appropriate temperature. *All residents have the potential to be affected. Ice cream and like desserts are iced for service, doors to the meal carts are closed after each tray removal, meals on memory care to be served on arrival from kitchen and temps taken. *Inservice education has been provided all appropriate staff members. Room meal trays will be on warmed plate, placed on hot pellet, placed in insulated bottom and covered with insulated dome lid. Ice cream and like desserts will be iced for service. The RD and/or dietary mgr will monitor room tray food temps 3x/week for 4 weeks, 1x/week for 3 months then monthly thereafter to assure compliance. RD and/or dietary manager monitoring of room meal temps will include all 3 meals. *Food temp monitoring will be brought to the monthly QA&A for review and follow for a minimum of 6 months and up until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/09/2013

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	Based on observation, interview and record review the facility failed to ensure food was served at the appropriate temperature in the main dining room, the Rehabilitation dining room, the Bed & Breakfast dining room, the 100 Hall & 200 Hall lounge, the 300 Hall lounge, and room trays in the 100 Hall, 200 Hall, 300 Hall, and Rehabilitation Halls, potentially affecting 112 of 114 residents who ate their meals prepared by the facility kitchen. Findings include: 1. During an observation of the lunch meal in the Rehabilitation Unit dining room on 1/30/13, the following was observed: - At 12:05 p.m., a large sheet pan containing 19 dessert bowls of vanilla ice cream was placed on the dining room counter for service during the lunch meal. Each bowl contained a large solid scoop of vanilla ice cream. The bowls of ice cream were not on ice and the temperature of the vanilla ice cream was not taken. - At 12:10 p.m., the service of the hot food began.			

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- At 12:12 p.m., the bowls of vanilla ice cream were served to those residents who were eating their meals in the Rehabilitation Unit dining room. The remaining 8 bowls of vanilla ice cream remained on the sheet pan on the counter. The bowls of vanilla ice cream were not on ice.

- At 12:27 p.m., a small service cart containing 5 room trays was pushed from the dining room. A bowl of vanilla ice cream was placed on each tray. Each bowl contained a small melted scoop of vanilla ice cream surrounded by a large amount of melted ice cream.

- At 12:28 p.m., the bowls of vanilla ice cream which had been placed on the dining room tables at 12:10 p.m. were mostly melted.

2. During an observation of the lunch meal on 1/31/13 the following was observed:

- At 11:25 a.m., Certified Nursing Assistant (CNA) #5 was observed to deliver room trays from the food cart, which had been placed in front of Room 101 on the 100 Hall. The doors to the foot cart were left open for 5

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	minutes. 3. Observation of lunch service on the Memory Care Unit on 1/31/13 at 11:05 a.m., dietary staff brought the following food to the kitchen service area and placed it in the steam table wells. The kitchen staff took the temperature of the food at that time. The fish was 145 degrees, corn was 155 degrees and the french fries were 140 degrees. Nursing staff began preparing resident food plates at 11:18 a.m. The staff did not check the temperature of the food at the time of service. 4. Observation of lunch service on the Memory Care Unit on 2/4/13 at 11:05 a.m., dietary staff brought the following food to the kitchen service area and placed it in the steam table wells. The kitchen staff took the temperature of the food at that time. The beef stew was 180 degrees, peas were 160 degrees and the applesauce was 40 degrees. Nursing staff began preparing resident food plates at 11:27 a.m.. The nursing staff did not check the temperature of the food at the time of service.			

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5. During an observation of the lunch meal on 2/4/13 at 11:35 a.m., the following was observed:

- At 11:35 a.m., the food cart was delivered to the 300 Hall in front of Room 301. CNA #3 was observed to deliver meal trays to Room 303 and Room 304. The door to the food cart was left open during the passing of the room trays, which took approximately 2 minutes.

- At 11:42 a.m. the food cart was pushed down the hallway from in front of Room 314 to in-between Room 318 and Room 320 by CNA #6. The door to the food cart was left open.

6. During an observation of the lunch meal in the facility kitchen on 2/5/13 at 11:00 a.m., the following was observed:

- At 11:00 a.m., 3 bowls of vanilla ice cream were placed on the preparation counter at the start of the meal service. The bowls were not on ice and the temperature of the vanilla ice cream was not taken.

- At 11:27 a.m., 1 of the bowls of vanilla ice cream was loaded onto a

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	meal tray in the food cart for the 100 Hall and 200 Hall. The bowl of vanilla ice cream was mostly melted. - At 11:45 a.m., another bowl of vanilla ice cream was loaded onto a meal tray in the food cart for the 300 Hall. The bowl of vanilla ice cream was mostly melted. - At 11:55 a.m., the final bowl of vanilla ice cream was put on a food tray to be served in the main dining room. The bowl of vanilla ice cream was mostly melted. Resident #15 was interviewed on 1/31/13 at 11:56 a.m. During the interview she indicated some meals were better than others. She also indicated she usually ate her meals in the lounge area between the 100 Hall and the 200 Hall and some of the hot food was served cold. She further indicated on 1/30/13, the evening meal food cart sat in the hallway for at least 15 minutes before the trays were served. A Minimum Data Set assessment for Resident #15, dated 10/19/12, indicated a score of 14 out of 15 on the Brief Interview for Mental Status. A review of the facility Resident Council Meeting Minutes, on			

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	12/27/12, indicated "...food has been cold a lot lately...One resident stated 'hot gravy does not heat up cold meat'...." A Resident Council Meeting response to the 12/27/12 meeting indicated meal trays would be sampled to ensure food was being served hot. A review of the facility Resident Council Meeting Minutes on 1/24/12, indicated "...food is often cold, especially vegetables...." A Resident Council Meeting response to the 1/24/12 meeting indicated maintenance checked the steam table in the kitchen and 2 of the wells were not as hot as they should be, which would possibly cause food to get colder faster. A Food Temperature Log for the lunch meal on 2/6/13, indicated the following food temperatures prior to the start of meal service: country fried steak - 170 degrees, mashed potatoes - 172 degrees, green beans - 176 degrees, peach cobbler - 38 degrees, and milk - 40 degrees. A test meal tray was requested from the Certified Dietary Manager for the lunch meal on 2/6/13. The test meal tray was placed on the food cart for the 100 Hall and 200 Hall and the			

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	temperatures were not taken until the last meal tray was served. The food temperatures were as follows: country fried steak - 140 degrees, mashed potatoes with gravy - 150 degrees, green beans - 120 degrees, peach cobbler - 50 degrees, and milk - 46 degrees. The Certified Dietary Manager (CDM) was interviewed on 2/5/13 at 11:25 a.m. During the interview she indicated complaints concerning cold food mostly come the residents who eat their meals in their room. The CDM was interviewed on 2/5/13 at 2:52 p.m. During the interview she indicated the doors to the food cart were to remain closed during the passing of room trays to help keep foods at the appropriate temperatures. A facility policy "Monitoring Trayline/Meal Service Temperatures", dated 2008 and provided by the Certified Dietary Manager on 2/6/13 at 12:12 p.m., indicated "...Employees of the Nutrition Services Department will be assigned to take and record the temperature of all hot and cold food items designated for service at each meal...Food items will be prepared in a manner that minimizes			

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	handling and exposure to temperatures within the 'danger zone' (41 - 135 degrees Fahrenheit)...Frozen foods are to be kept frozen and should be stored and maintained at 0 degrees Fahrenheit or below...." A facility policy "Proper Food Handling", dated 2012 and provided by the Administrator on 2/6/13 at 8:40 a.m., indicated "...Prepared food should be transported to other areas in closed food carts or containers...." 3.1-21(a)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to transport room meal trays safely through the hallways and handle drinking glasses to prevent potential contamination, and failed to wash hands appropriately potentially affecting 112 of 114 residents who ate meals prepared by the facility. Findings include: 1. During an observation of the lunch meal on 1/30/13, the following was observed: - At 11:50 a.m., Certified Nursing Assistant (CNA) #7 was observed to carry a room tray from the the food cart, which had been placed in front of Room 115 on the 100 Hall, through the hallway to Room 120. A bowl of cottage cheese and a slice of chocolate cake were not covered.	F0371	F371: *Room meal trays will be transported safely through hallways, hand washing and drinking glasses will be handled in a manner to prevent potential contamination. *All residents have the potential to be affected. Inservice education has been provided all appropriate staff members. All items on trays are covered, food cart doors are closed after each tray is removed, proper handwashing technique is maintained. *The RD and/or dietary mgr will monitor room meal delivery, handling of glasses 3x/week for 4 weeks, 1x/week for 3 months then monthly thereafter. The Staff Development Coordinator will monitor handwashing thru observations of a minimum of 5 staff members/week during random meal service. The RD and/or dietary manager monitoring of room meal delivery, handling of glasses will include all 3 meals. *Monitoring of room meal delivery, handwashing and handling of glasses will be brought to the monthly QA&A for a minimum of 6 months for review and follow up and until the	03/09/2013

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	- At 11:52 a.m., CNA #8, was observed to carry a room tray from the food cart, which still remained in front of Room 115, through the 100 Hall to the pantry to keep for a resident until her return from an outside appointment. A bowl of pudding was not covered. - At 11:53 a.m., CNA #9, was observed to carry a room tray from the food cart, which had now been placed in front of the linen room on the 200 Hall, through the 100 Hall to Room 118. A bowl of tossed salad with a small paper cup of salad dressing and a slice of chocolate cake were not covered. - At 11:55 a.m., CNA #9 and CNA #8 were observed to carry room trays from the food cart, which remained in front of the linen room, through the 200 Hall to 10 resident rooms. Bowls of tossed salad with small paper cups of salad dressing and slices of chocolate cake were not covered. - At 12:05 p.m., CNA #9 and CNA #8 were observed to carry 4 meal trays from the food cart, which remained in front of the linen room, around the corner and through the 100 Hall into the small lounge area on the corner of		facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	

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	the 100 Hall and 200 Hall. Bowls of tossed salad with small paper cups of salad dressing, bowls of fruit, bowls of jello, bowls of pudding, and slices of chocolate cake were not covered. 2. During an observation of the lunch meal on 1/31/13, the following was observed: - At 11:25 a.m., CNA #5 was observed to deliver room trays from the food cart, which had been placed in front of Room 101 on the 100 Hall, to Room 103 and Room 101. The doors to the food cart were left open to the 100 Hall for 5 minutes. Facility employees and visitors were observed walking past the open doors of the food cart with the exposed room trays. - At 11:32 a.m., CNA #5 was observed to carry a room tray from the food cart, which remained in front of Room 101, to Room 105. A bowl of ice cream was not covered. - At 11:35 a.m., CNA #5 was observed to push the food cart from in front of Room 101 to in front of Room 109. She was then observed to carry a room tray to Room 107 and to Room 106. Bowls of tossed salad			

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	with small paper cups of salad dressing and bowls of ice cream were not covered. - At 11:40 a.m., the food cart was moved in front of Room 201 on the 200 Hall. Several un-identified CNA's were observed to carry 10 meal trays through the 200 Hall to resident rooms and the small lounge area between the 100 Hall and the 200 Hall. Bowls of tossed salad with small paper cups of salad dressing and bowls of ice cream and mugs of coffee were not covered. - At 11:50 a.m., an un-identified male CNA was observed to carry a meal tray from the food cart through the 300 Hall and through the main entrance hallway to the main dining room for a resident seated at a dining room table. A bowl of ice cream was not covered. 3. During an observation of the lunch meal on 1/31/13 in the Rehabilitation Unit the following was observed: - At 12:11 p.m., CNA #10 was observed to wash her hands for a maximum of 13 seconds and used her bare hands to turn off the water faucet. She was not observed to use			

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	a paper towel as a barrier. - At 12:15 p.m., Housekeeping #11 was observed to wash her hands for a maximum of 12 seconds. - At 12:19 p.m., CNA #10 was observed to open a cabinet door and remove 2 small drinking glasses which were stacked inside each other. She was observed to hold the drinking glasses in her right palm with her hand surrounding and touching the rims of the drinking glasses. Determining they were not needed, she was observed to place them back inside the cabinet. 4. During an observation of the lunch meal on 2/4/13 at 11:35 a.m., the following was observed: - At 11:35 a.m., the food cart was delivered to 300 hall in front of Room 301. CNA #3 was observed to deliver meal trays to Room 303 and Room 304. The door to the food cart was left open during the passing of the room trays exposing the meal trays to the 300 Hall. - At 11: 37 a.m., CNA #3 was observed to close the door to the food cart and push the food cart down the			

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	hallway in front of Room 310. She then carried a meal tray from the food cart through the hallway to Room 305. A bowl of fruit was not covered. - At 11:39 a.m., CNA #3 and LPN #12 carried meal trays to Room 317 and Room 314, respectively. The bowls of fruit were not covered. - At 11:42 a.m. the food cart was pushed down the hallway in-between Room 318 and Room 320 by CNA #6 The door to the food cart was left open exposing the meal trays to the 300 Hall. - At 11:46 a.m., the Certified Dietary Manager (CDM) was observed to carry a meal tray from the food cart through the 300 Hall and through the main entrance hallway to the main dining room for a resident seated at a dining room table. A bowl of fruit was not covered. 5. During an observation of the lunch meal in the facility kitchen on 2/5/13 at 10:45 a.m., the following was observed: - At 10:45 a.m. and at 10:49 a.m., Cook #13 was observed to wash his hands for the appropriate amount of			

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	time and used his bare hands to turn off the water faucet. He was not observed to use a paper towel as a barrier. - At 10:55 a.m., Cook #13 was taking temperatures of the food on the kitchen trayline. While taking the temperatures, he was observed to sneeze into his sleeve. He did not stop and immediately wash his hands, but continued to take the temperatures of the food. - At 11:03 a.m., Cook #13 was observed to wash his hands for a maximum of 10 seconds and used his bare hands to turn off the water faucet. He was not observed to use a paper towel as a barrier. - At 11:33 a.m., Dietary Assistant #14 re-entered the kitchen after taking the food cart to the 100 Hall. He was not observed to wash his hands upon his return to the kitchen and handled clean coffee mugs for residents seated in the main dining room for lunch. 6. During lunch service in the Rehabilitation dining room on 1-30-2013 at 12:14 p.m., the Director of Environmental Services (#24) was observed discarding an item in the			

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	trash and used his hand to open the trash container lid. He served a resident a hot drink and desserts to 4 different residents without washing hands or performing hand hygiene. During the lunch service in the Rehabilitation dining room on 1-30-2013 at 12:15 p.m., Director of Environmental Services #24 touched his mouth with his hand and served a plate of food to a resident without washing his hands or performing hand hygiene. During the dining service in the Rehabilitation dining room on 1-30-2013 at 12:21 p.m., Housekeeper #11 was observed discarding something in the trash and used her hand to open the trash container lid. Housekeeper #11 served a resident a bowl of food and took two hall trays to residents without washing hands or performing hand hygiene. During the dining service in the Rehabiltation dining room on 1-30-2013 at 12:28 p.m., LPN #21 picked up a spoon and fed a resident a bite of food without washing hands or performing hand hygiene.			

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	7. During the dining service in the Rehabilitation dining room on 1-31-2013 at 12:20 p.m., Housekeeper #11 touched a resident on the back and touched the resident's wheelchair with her hands and proceeded to cut up a resident's french fries, get refills on drinks for 2 residents and served another resident their meal without washing hands or performing hand hygiene. An interview with Housekeeper #11 on 2-6-2013 at 10:14 a.m., indicated she was aware of the policy for handwashing for meal service. She indicated handwashing was for 20 seconds and she was aware she was to wash her hands after touching a resident and after touching the trash containter lid. The CDM was interviewed on 2/5/13 at 2:52 p.m. During the interview she indicated dietary staff were to wash their hands for 15 to 20 seconds and were to use a paper towel as a barrier to turn off the water faucet. She also indicated the food cart should be pushed down the hallway to each room when delivering room trays and the cart doors should be kept closed A facility policy "Hand Hygiene",			

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	dated 2012 and provided by the Certified Dietary Manager on 2/5/13 at 3:00 p.m., indicated "...Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections...Wash well under running water for a minimum of 15 seconds, using a rotary motion and friction; Rinse hands well under running water; Dry hands with a clean paper towel...Use the paper towel to turn off the faucet, then discard...." A facility policy "Dietary Services", dated 2012 and provided by the Administrator on 2/6/13 at 8:40 a.m., indicated "...To prevent contamination of food products and therefore prevent foodborne illness...Wash hands carefully with soap and water whenever they become soiled...after coughing, sneezing, or blowing the nose...." 3.1-21(i)(2) 3.1-21(i)(3)			

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F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F0431	F431: *Insulins and eye drops will be dated after opened. The undated medication for residents #239, 225, 216, & 54 were replaced. *Residents receiving	03/09/2013

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	Based on observation and interview the facility failed to ensure insulin and eye medications were dated after being opened on 1 of 4 units. (residents #239, #225, #216 and #54) Finding Includes: On 2/5/13 at 2:55 p.m., observation of the medication cart on the Rehab Unit indicated the following medications had been opened but were not dated. Resident #225- 1 container of Artificial Tears Resident #54- 1 bottle of Novolog Insulin Resident #216- 1 bottle of Novolog Insulin Resident #239- 1 bottle of Novolin R Insulin Interview with nurse #15 on 2/5/13 at 3:00 p.m., indicated the staff should be dating insulin and eye drops when they are opened. Review of the Pharmacy Services and Procedures Manual, dated 5/10/10 indicate the following: "Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."		insulin and eye drops have the potential to be affected. The facility reviewed all open insulin and eye medications to ensure containers were dated and replaced as appropriate. *Licensed staff were re-educated to date medication containers when opened. UM/designee will monitor compliance through cart observations 5x/week./1 month then 1x/week for 3 months, then monthly thereafter. *Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 months and until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	

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	3.1-25(k)(6)			

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F0504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview the facility failed to ensure laboratory blood draws were completed as ordered for 1 of 10 residents who's records were reviewed for laboratory services. (resident #129) Finding includes: On 2/1/13 at 1:30 p.m. review of the clinical record for resident #129 indicated he was admitted to the facility on 4/25/11 with diagnoses including but not limited to dementia with delusions, insomnia, depression, hypertension, seizure disorder, and brain disease with paraneoplastic encephalomyelitis, and agitation with psychosis. Review of the resident's physician orders dated 1/30/13 indicated the resident was to have a phenytoin level every month, a complete blood count every three months and a basic metabolic profile every three months. Review of the record indicated the last phenytoin level done for the resident was completed on 4/19/12,	F0504	F504: *Lab draws will be completed as ordered Resident #129 labs were obtained. *All residents have the potential to be affected. The facility reviewed all resident labs to ensure results were received and obtained labs where appropriate. *Licensed staff were inserviced regarding obtaining labs in a timely manner. UM/designee will monitor lab orders to ensure completeness monthly. *Results of audits will be forwarded to QA&A committee for tracking and trending monthly for a minimum of 6 month and until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/09/2013

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	the last complete blood count was completed on 2/16/12, and the last basic metabolic profile was completed on 2/16/12. Interview on 2/4/13 at 2:00 p.m. with nursing staff supervisor #1 indicated the facility knew this was a problem and had added it to their Quality Assurance Program. She indicated the laboratory the facility uses was suppose to send a list of all lab orders that were a year old. She indicated that after a year the lab discontinues the orders. Interview with the Director of Nursing on 2/4/13 at 2:30 p.m. indicated the lab had stopped sending the expired yearly list. 3.1-49(f)(1)			

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F0520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility failed to identify and implement a plan of action for the identified concerns of proper food temperatures, sanitary food service, dining service, accident hazards and prevention, and ensuring assessments, care plans, and treatments were completed. This deficient practice had the potential to affect 114 of 114 residents residing in the facility.	F0520	F520: *This facility will identify and implement a plan of action for identified concerns of proper food temps, sanitary food services, dining service, accident hazards & prevention, and ensuring assessments, care plans and treatments are completed. *All residents have the potential to be affected. Inservice education has been provided to all appropriate staff and plans of action have been initiated. To assure proper food temps, sanitary food services,	03/09/2013

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	155446	A. BUILDING _____ B. WING 00	02/07/2013

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	Findings include: An interview with the Administrator on 2-5-2013 at 4:30 p.m., indicated he was unaware of the food temperature, sanitary food and dining service concerns. An interview with the Administrator on 2-6-2013 at 9:35 a.m., indicated clinical audits were being done regarding physician orders, lab orders and change of condition process. The Administrator indicated the facility had implemented guardian angel rounds with each department head assigned to a resident room and the residents within the room. The purpose was to ensure the rooms were in order and to check on the residents. Resident concerns are tracked and if trends were identified, they are discussed at daily department head meetings and at the monthly Quality Assurance meetings. An interview with the Administrator, DON, RN Director of Clinical Operations and the Clinical Consultant on 2-7-2013 at 9:00 a.m., indicated they were not aware of the concerns for the accident hazards and prevention and they were not aware of the concerns for ensuring		dining service, accidents & prevention, assessments, care plans and treatments are current. *Resident room meal trays will be served on heated plates, placed on heated pellets, and covered with insulated dome and bottom to assure compliance. Meal cart doors will be closed after each tray removal. Beverages and cold desserts will be iced at service. The coffee pot has been relocated to a secure area. An audit has been completed and all care plans, assessments and treatments are current per orders. *The RDand/or dietary mgr will audit food temps on the units 3x/week for 4 weeks, 1x/week for 3 months and monthly thereafter to assure compliance. To assure compliance with appropriate urinary voiding patterns the DON/designee will audit 5 incontinent residents/week, The UMs/designee will monitor compliance with care plan development for high risk skin and falls during admission audits and IDT walking rounds. UMs will monitor compliance with treatment orders through daily medical record review 5x/week. All audits are brought to the monthly QA&A for review and follow up monthly for a minimum of 6 months and until the facility has a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.. The QA&A	

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	assessements, care plans, and treatments were completed as ordered. There was no evidence the Administrator, DON, and the Quality Assessment and Assurance Committee had a system in place to identify problems, or to implement action plans to address concerns including proper food temperatures, sanitary food service, dining service, accident hazards and prevention, and ensuring assessments, care plans, and treatments were completed. 3.1-52(a)(2)		Committee will identify concerns and implement action plans going forward thru daily IDT walking rounds, Guardian Angel daily rounds, resident/family interviews, and use of the facility internal QA tools.	

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F9999	3.1-14 PERSONNEL 1. (t) A physical examination shall be required for each employee of a facility within one(1) month prior to employment. The examination shall include a tuberculin skin test using the Mantoux method (5 TU PPD), administered by persons having documentation of training form a department-approved course of instruction in intradermal tuberculin skin testing reading, and recording unless a previously positive reaction can be documented. The results shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one(1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve(12) months, the baseline tuberculin skin testing should employ	F9999	F9999: *All newly hired employees will receive the required TB screening and annual dementia training. *All residents have the potential to be affected. All current employees are current with required TB screening and annual dementia training. *All personnel files have been audited for compliance. Hiring managers have been inserviced as well as the HR manager, keeper of the personnel files in the business office. The Administrator will randomly audit a minimum of 3 newly hired employee personnel files per month as well as 3 personnel files of individual who have been employed 12 months or more to assure compliance. *Personnel file audit results will be brought to the monthly QA&A committee for review and follow up monthly for a minimum of 6 months and until we have a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/09/2013

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	the two-step method. If the first step is negative, a second test should be performed one(1) to three(3) weeks after the first step. the frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on record review and interview the facility failed to ensure their employees were tested for tuberculosis using the two-step Mantoux method for newly hired employees and Mantoux tuberculin skin testing at least annually thereafter for 6 of 13 employee who's records were review for TB testing. (CNA #5, CNA #17, CNA #18, LPN #19, CNA #20 and Dietary Manager(DM)). Findings include: 1. A review of employee records on 2/6/13 at 1:30 p.m., CNA #5's employee records indicated she was hired on 8/13/12. The health records indicated, CNA #5 received Step 1, Mantoux TB test (tuberculin skin test) on 8/7/12 at 11:00 a.m., and the test site was read on 8/9/12 at 1:30 p.m., results were 0 mm (millimeters, a measurement) induration (hardening			

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	or hardness). There were no records indicating the Step 2 of the Mantoux TB test had been done. CNA # 5's health record indicated she received a repeated Step 1 Mantoux TB test on 2/1/13 at 11:35 a.m., with Step 2 to follow on 2/15/13. 2. A review of employee records on 2/6/13 at 1:30 p.m., CNA #17's employee records indicated she was hired on 11/19/12. The health records indicated, CNA #17 received Step 1, Mantoux TB test on 11/16/12 at 9:35 a.m. and the test site was read on 11/19/12 at 9:30 a.m., results were 0 mm induration. Step 2, Mantoux TB test was done on 1/7/13 at 10:55 a.m., which was more than 3 weeks after Step 1 of the Mantoux TB test was done. 3. A review of employee records on 2/6/13 at 1:30 p.m., CNA #18's employee records indicated she was hired on 11/19/12. The health records indicated, CNA #18 received Step 1, Mantoux TB test on 11/16/12 at 11:35 a.m. and the test site was read on 11/19/12 at 9:30 a.m., results were 0 mm induration. There were no records indicating the Step 2, Mantoux TB test had been done. CNA #18's health records indicated CNA # 18 received a repeated Step			

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	1, Mantoux TB test on 2/1/13 at 6:00 a.m., with Step 2 to follow on 2/15/13. 4. A review of employee records on 2/6/13 at 1:30 p.m., LPN #19's employee records indicated she was hired on 12/6/12. The health records indicated, LPN #19 received Step 1, Mantoux TB test on 11/26/12 at 4:15 p.m. and the test site was read on 11/28/12 at 4:00 p.m., results were 0 mm induration. There were no record indicating Step 2, Mantoux TB test had been done. LPN #19's health records indicated LPN #19 received a repeated Step 1, Mantoux TB test on 1/30/13 at 2:00 p.m., with Step 2 to follow on 2/15/13. 5. A review of employee records on 2/7/13 at 10:30 a.m., CNA # 20's employee records indicated she was hired on 11/19/12. The health records indicated CNA #20 received Step 1, Mantoux TB test on 11/16/12 at 10:05 a.m. and the test site was read on 11/19/12 at 9:30 a.m., results were 0 mm induration. The health records indicated Step 2, Mantoux TB test was done on 12/19/12 at 9:45 a.m., which was more than 3 weeks after Step 1 of the Mantoux TB test was done. 6. On 2/6/12 at 1:30 p.m. a review of			

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	DM's employee heath records indicated that she did not have an annual Mantoux TB test done in 2012. 7. During an interview with Director of Staff Development (DSD), on 2/7/13 at 10:15 a.m., she indicated there was not a written facility policy or protocol for Mantoux TB testing for employees, and indicated the state and federal regulations were followed by the facility. She also indicated that she had just started working as the DSD in November 2012. She was not aware of a protocol to track the Mantoux TB testing for the facility employees when she started in November. 8. On 2/7/13 at 8:47 a.m., the Administrator provided the facility policy for Personnel Files and Records, dated 06/01/98, revision date: 04/02. The policy states, "...It is the policy of Covenant Care that personnel records will be maintained for all employees in compliance with this policy and state and federal requirements.... F. The employee's Medical file includes, but not limited to , the following documents: State required medical testing, including TB testing...."			

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	2. (u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six(6) months of initial employment, or within thirty(30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three(3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview the facility failed to ensure the annual three(3) hour dementia training was completed for 1 of 5 employee records reviewed for the annual dementia training. (LPN #1, Unit Manager) Findings include: 1. On 2/6/13 at 1:30 p.m., a review of LPN #1's, a Unit Manger, employee record indicated there was no record			

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	of the required annual 3 hour dementia inservice for 2012. 2. An interview with the Director of Staff Development, on 2/6/13 at 4:40 p.m., indicated there was no record of LPN #1 completing the annual 3 hour dementia inservice in 2012. There was not a 3 Hour Dementia Certificate of Completion in her employee file and her name was not on the any of the facility inservice sign-in sheets for the annual dementia inservice training. 3. An interview with Administrator on 2/7/13 at 11:58 a.m., indicated there is not a facility policy for dementia training and the facility follows state and federal rules and regulations for dementia training and inservices.			